| IPDR6702  | : 09/25/2005                   |             | Tpno      | NORTH CAROLINA<br>CHECKWRITE SUMMARY REPORT     |          | PAGE:            | 1  | +  |
|-----------|--------------------------------|-------------|-----------|---|----------|------------------|--|--|
| NON DAIL. | . 03/23/2003                   |             |           | ECKWRITE DATE: 09/29/2005                       |          |                  |  | +  |
|           |                                |             |           | FINANCIAL PAYER: NCDMH                          |          |                  |  |  |
|           |                                |             |           |   |          |                  |  |  |
| PROVIDER  |                                | HIGH DENIAL | NUMBER OF |   |          |                  | TOTAL  | TOTAL  |
| NUMBER    | PROVIDER NAME                  | EOBS        | DENIALS   | DESCRIPTION                                     | TNC      | TOTAL<br>DENIALS | CLAIMS<br>FINALIZED                              | CLAIMS   |
|           |                                |             |           |   |          |                  |  |  |
| 3404901   | SMOKY MOUNTAINM                | 0           | 0         | *** NO DATA TO REPORT ***                       |          |                  |  |  |
|           | H/DD/SAS                       |             |           |   |          |                  |  |  |
|           |                                |             |           |   |          |                  |  | -  |
|           |                                | 0           | 0         |   |          | 0                | 0  | ) 0  |
|           |                                |             |           |   |          |                  |  | <del></del>                                      |
|           |                                |             |           |   |          |                  |  |  |
| 3404904   | WESTERN HIGHLAN                | 8599        | 181       | DETAIL NOT COVERED BY COMBINAT                  |          |                  |  |  |
|           | DS LME                         |             |           | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. |          |                  |  |  |
|           |                                |             |           | BENEFII PACKAGE.                                |          |                  |  |  |
|           |                                | 143         | 18        | CLIENT ID NUMBER NOT ON STATE                   | 1        | . 223            | 6229   | 9 6006   |
|           |                                |             |           | ELIGIBILITY FILE                                |          |                  |  |  |
|           |                                |             |           |   |          |                  |  |  |
|           |                                |             |           |   |          |                  |  |  |
|           |                                | 191         | 15        | CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME   |          |                  |  | <del>                                     </del> |
|           |                                |             | 1         | ENI WANE  |          |                  | <del>                                     </del> | +  |
|           |                                |             | 1         | +   |          |                  | <del> </del>                                     | +  |
| 3404910   | PATHWAYS                       | 8599        | 2650      | DETAIL NOT COVERED BY COMBINAT                  |          |                  |  | 1  |
|           |                                |             |           | ION OF RECIPIENT, PROVIDER AND                  |          |                  |  |  |
|           |                                |             |           | BENEFIT PACKAGE.                                |          |                  |  | 1  |
|           |                                | 10          | 28        | DIAGNOSIS OR SERVICE INVALID F                  |          |                  | <del> </del>                                     | +  |
|           |                                |             |           | OR CLIENT AGE. VERIFY CID,                      | 1        | 2695             | 2793   | 98   |
|           |                                |             |           | DIAGNOSIS, PROCEDURE CODE FOR                   |          |                  |  |  |
|           |                                |             |           |   |          |                  |  |  |
|           |                                | 11          | 15        | CLIENT NOT ELIGIBLE ON SERVICE                  |          |                  |  |  |
|           |                                |             |           | DATE  |          |                  |  |  |
|           |                                |             |           |   |          |                  |  |  |
| 3404912   | CATAWBA COUNTYM                | 11          | 127       | CLIENT NOT ELIGIBLE ON SERVICE                  |          |                  | -  | +  |
|           | ENTAL HEALT                    |             |           | DATE  |          |                  |  | +  |
|           |                                |             |           |   |          |                  |  |  |
|           |                                |             |           |   |          |                  |  |  |
|           |                                | 8599        | 2         | DETAIL NOT COVERED BY COMBINAT                  | 1        | 132              | 551  | 1 419  |
|           |                                |             |           | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. |          |                  |  |  |
|           |                                |             |           | Barrer Marian.                                  |          |                  |  | +  |
|           |                                | 167         | 2         | NO CHARGE BILLED. ENTER BILLED                  |          |                  |  | +  |
|           |                                |             |           | AMOUNT AND SUBMIT DETAIL AS                     |          |                  |  |  |
|           |                                |             |           | A NEW CLAIM                                     |          |                  |  |  |
| 3404913   |                                |             | 0         | *** NO DATA TO REPORT ***                       |          |                  |  |  |
| 3404913   | MECKLENBURG COM<br>ENTAL HEALT | 0           | 0         | NO DATA TO REPORT                               |          |                  |  |  |
|           | ENIAL REALI                    |             |           |   |          |                  |  |  |
|           |                                |             |           |   |          |                  |  | 1  |
|           |                                | 0           | 0         |   | C        | 0                | 135  | 5 135  |
|           |                                |             |           |   |          |                  |  |  |
| 3404916   | CROSSROADS BEHA                | 8621        | 82        | 60 RESIDENTIAL LEVEL III TREAT                  |          | 1                | +  | -  |
|           | CROSSROADS BEHA<br>VIORAL HEAL |             |           | MENT RECEIVED, PA IS REQUIRED                   | <u> </u> | +                | +  | +  |
|           |                                |             |           | FOR ADDITIONAL SERVICE.                         |          |                  |  | 1  |
|           |                                |             |           |   |          |                  |  |  |
|           |                                | 21          | 68        | DUPLICATE OF CLAIM-SYSTEM                       | 5        | 312              | 6877   | 7 6565   |
|           |                                |             |           |   |          |                  | +  | +  |
|           |                                |             |           |   |          | -                | <del>                                     </del> | +  |
|           |                                | 10          | 34        | DIAGNOSIS OR SERVICE INVALID F                  |          |                  | <del>                                     </del> | +  |
|           |                                |             |           | OR CLIENT AGE. VERIFY CID,                      |          |                  |  |  |
|           |                                |             |           | DIAGNOSIS, PROCEDURE CODE FOR                   |          |                  |  |  |
| 24040**   |                                | 21          | C222      | DUDY YOUND OF GLATH OVER                        |          |                  |  | $\perp \equiv$                                   |
| 3404917   | CENTERPOINT HUM                | 21          | 6737      | DUPLICATE OF CLAIM-SYSTEM                       |          |                  | +  | +  |
|           | AN SERVICES                    |             |           | +   |          |                  | <del>                                     </del> | +  |
|           |                                |             |           |   |          |                  | <del>                                     </del> | +  |
|           |                                | 8599        | 680       | DETAIL NOT COVERED BY COMBINAT                  | 136      | 8690             | 21260  | 12570  |
|           |                                |             |           | ION OF RECIPIENT, PROVIDER AND                  |          |                  |  |  |
|           |                                |             |           | BENEFIT PACKAGE.                                |          |                  |  |  |
|           |                                | 8329        | 487       | CLAIM DENIED ATTENDING PROVIDE                  |          |                  | <del>                                     </del> | +  |
|           |                                |             | 1         | R CANNOT BE THE SAME AS                         |          |                  | <del>                                     </del> | +  |
|           |                                |             |           | THE LMA   |          |                  | <del>                                     </del> | +  |
|           |                                |             |           |   |          |                  |  | 1  |
| 3404918   | ROCKINGHAM CO M                | 0           | 0         | *** NO DATA TO REPORT ***                       |          |                  |  |  |
|           | ENTAL HEALT                    |             |           |   | ļ        | 1                | <u> </u>   | ₩  |
|           |                                |             |           |   |          |                  | +  | +  |
|           | i i                            | 1           | 1         |   | 1        | l .              | <u> </u>   |  |
|           |                                | 0           | 0         |   |          | ^                | ^  | 1 0  |
|           |                                | 0           | 0         |   | C        | 0                | 0  | 0 0  |

|          |                 |             |           | T  | T       |  |           |       |
|----------|-----------------|-------------|-----------|--|---------|--|-----------|-------|
| PROVIDER |                 | HIGH DENIAL | NUMBER OF |  | TNC     | TOTAL  | TOTAL     | TOTAL |
| NUMBER   | PROVIDER NAME   | EOBS        | DENIALS   | DESCRIPTION  | DENIALS | DENIALS  | FINALIZED | PAID  |
|          |                 |             |           |  |         |  |           |       |
| 3404919  | GUILFORD CO MEN | 0           | 0         | *** NO DATA TO REPORT ***                                      |         |  |           |       |
|          | TAL HEALTHC     |             |           |  |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
|          |                 | 0           | 0         |  | 0       | 0  | 93        | 93    |
|          |                 |             |           |  |         |  |           |       |
| 2101000  |                 | 0500        | 1.50      |  |         |  |           |       |
| 3404920  | ALAMANCE CASWEL | 8599        | 160       | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND  |         |  |           |       |
|          | L AREA MH D     |             |           | BENEFIT PACKAGE.   |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
|          |                 | 5404        | 147       | SEVERE DUPLICATE: SAME ATTD PR                                 | 52      | 521  | 3521      | 3000  |
|          |                 |             |           | OV/PCODE/TOS/DOS/MOD   |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
|          |                 | 21          | 91        | DUPLICATE OF CLAIM-SYSTEM                                      |         |  |           |       |
|          |                 | 21          | 91        | DOPLICATE OF CLAIM-SISTEM                                      |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
| 3404921  | ORANGE PERSON C | 8599        | 708       | DETAIL NOT COVERED BY COMBINAT                                 |         |  |           |       |
|          | HATHAM AREA     |             |           | ION OF RECIPIENT, PROVIDER AND                                 |         |  |           |       |
|          |                 |             |           | BENEFIT PACKAGE.   |         |  |           |       |
|          | +               | 21          | 191       | DUPLICATE OF CLAIM-SYSTEM                                      |         |  |           |       |
|          |                 |             | - 71      | DOLLIGHTE OF CHAIN-SISIEM                                      | 8       | 1218   | 7323      | 6105  |
|          |                 |             |           |  |         | <b>-</b>   |           |       |
|          |                 |             |           |  |         |  |           |       |
|          |                 | 5312        | 115       | PRIOR AUTHORIZED DOLLARS EXCEE                                 |         |  |           |       |
|          |                 |             |           | DED  |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
| 3404922  |                 | 0220        | 60        | COLATA DENTED AMMENDANC DECUADO                                |         |  |           |       |
| 3404922  | THE DURHAM CENT | 8329        | 60        | CLAIM DENIED ATTENDING PROVIDE R CANNOT BE THE SAME AS         |         |  |           |       |
|          | ER              |             |           | THE LMA  |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
|          |                 | 191         | 1         | CLIENT ID NUMBER DOES NOT MATC                                 | 0       | 61   | 63        | 2     |
|          |                 |             |           | H PATIENT NAME   |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
| 3404923  | FIVE COUNTY MH  | 8622        | 65        | 60 RESIDENTIAL LEVEL II TREATM                                 |         |  |           |       |
|          |                 |             |           | ENT RECEIVED, PA IS REQUIRED  FOR ADDITIONAL SERVICE.          |         |  |           |       |
|          |                 |             |           | TON HEBETTONIE CENTUCE.  |         |  |           |       |
|          |                 | 8599        | 50        | DETAIL NOT COVERED BY COMBINAT                                 | 0       | 125  | 682       | 557   |
|          |                 |             |           | ION OF RECIPIENT, PROVIDER AND                                 | -       |  |           |       |
|          |                 |             |           | BENEFIT PACKAGE.   |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
|          |                 | 191         | 4         | CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME                  |         |  |           |       |
|          |                 |             |           | H PATIENT NAME   |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
| 3404925  | SANDHILLS CENTE | 8599        | 273       | DETAIL NOT COVERED BY COMBINAT                                 |         |  |           |       |
|          | R FOR MH/DD     |             |           | ION OF RECIPIENT, PROVIDER AND                                 |         |  |           |       |
|          |                 |             |           | BENEFIT PACKAGE.   |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
|          |                 | 21          | 177       | DUPLICATE OF CLAIM-SYSTEM                                      | 47      | 829  | 8710      | 7881  |
|          |                 |             | 1         |  |         | <del></del>                                      |           |       |
|          |                 |             |           |  |         | <b>-</b>   |           |       |
|          |                 | 11          | 96        | CLIENT NOT ELIGIBLE ON SERVICE                                 |         |  |           |       |
|          |                 |             |           | DATE   |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
| 3404926  |                 | 8535        | 1592      | SERVICE FACTION INCOME.  |         | 1  |           |       |
| ~4043Zp  | SOUTHEASTERN RE | 8535        | 1592      | SERVICE FACILITY LOCATION WAS<br>NOT INCLUDED IN YOUR 837.     |         | <del>                                     </del> |           |       |
|          | G MENTAL HL     |             | 1         | PLEASE RESUBMIT YOUR CLAIM WIT                                 |         | <del>                                     </del> |           |       |
|          |                 |             |           |  |         |  |           |       |
|          |                 | 11          | 95        | CLIENT NOT ELIGIBLE ON SERVICE                                 | 16      | 1763   | 3145      | 1382  |
|          |                 |             |           | DATE   |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
|          |                 | 8599        | 24        | DETAIL NOT COVERED BY COMBINAT                                 |         |  |           |       |
|          |                 | 0333        | ~ 7       | DETAIL NOT COVERED BY COMBINAT  ION OF RECIPIENT, PROVIDER AND |         | -  |           |       |
|          | +               |             | 1         | BENEFIT PACKAGE.   |         | <del>                                     </del> |           |       |
|          |                 |             |           |  |         |  |           |       |
| 3404927  | CUMBERLAND CO M | 8599        | 108       | DETAIL NOT COVERED BY COMBINAT                                 |         |  |           |       |
|          | HC              |             |           | ION OF RECIPIENT, PROVIDER AND                                 |         |  |           |       |
| -        |                 |             |           | BENEFIT PACKAGE.   |         |  |           |       |
|          |                 | 0640        | 10        | CLAIM DENTED MAYIMAN ATTOWNS C                                 |         |  |           |       |
|          |                 | 8649        | 13        | CLAIM DENIED MAXIMUM ALLOWED 2 6 OCCURRENCES HAVE PROCESSED    | 0       | 140  | 5292      | 5152  |
|          | T.              |             | 1         | AND PAID, PA IS REQUIRED.                                      |         |  |           |       |
|          |                 |             | 1         | -,   |         |  |           |       |
|          |                 |             |           |  |         |  |           |       |
|          |                 | 21          | 10        | DUPLICATE OF CLAIM-SYSTEM                                      |         |  |           |       |
|          |                 | 21          | 10        | DUPLICATE OF CLAIM-SYSTEM                                      |         |  |           |       |
|          |                 | 21          | 10        | DUPLICATE OF CLAIM-SYSTEM                                      |         |  |           |       |

| PROVIDER |                                | UTCH DENTAL         | NUMBER OF |  |         |  | TOTAL               | TOTAL          |
|----------|--------------------------------|---------------------|-----------|--|---------|--|---------------------|----------------|
| NUMBER   | PROVIDER NAME                  | HIGH DENIAL<br>EOBS | DENIALS   | DESCRIPTION  | TNC     | TOTAL<br>DENIALS                                 | CLAIMS<br>FINALIZED | CLAIMS<br>PAID |
|          | PROVIDER NAME                  |                     |           |  | DENIALS | DENTALS  | FINALIZED           | FALL           |
| 3404929  | LEE HARNETT MH/                | 0                   | 0         | *** NO DATA TO REPORT ***                                      |         |  |                     |                |
|          | DD/SAS                         |                     |           |  |         |  |                     |                |
|          |                                |                     |           |  |         |  |                     |                |
|          |                                | 0                   | 0         |  |         | 0  | 0                   |                |
|          |                                |                     |           |  |         |  | 0                   |                |
|          |                                |                     |           |  |         |  |                     |                |
| 3404930  | JOHNSTON COUNTY                | 191                 | 2         | CLIENT ID NUMBER DOES NOT MATC                                 |         |  |                     |                |
|          | MNTL HLTHC                     |                     |           | H PATIENT NAME   |         |  |                     |                |
|          |                                |                     |           |  |         |  |                     |                |
|          |                                | 0                   | 0         |  | 0       | 2  | 55                  | 53             |
|          |                                |                     |           |  |         | _  | 33                  |                |
|          |                                |                     |           |  |         |  |                     |                |
| 3404931  | WAKE CO HUM SVC                | 11                  | 188       | CLIENT NOT ELIGIBLE ON SERVICE                                 |         |  |                     |                |
|          | BILLING OF                     |                     |           | DATE   |         |  |                     |                |
|          |                                |                     |           |  |         |  |                     |                |
|          |                                | 8599                | 99        | DETAIL NOT COVERED BY COMBINAT                                 | 15      | 395  | 5941                | 5546           |
|          |                                |                     |           | ION OF RECIPIENT, PROVIDER AND                                 | 13      | 393  | 3941                | 3346           |
|          |                                |                     |           | BENEFIT PACKAGE.   |         |  |                     |                |
|          |                                |                     |           |  |         |  |                     |                |
|          |                                | 8622                | 32        | 60 RESIDENTIAL LEVEL II TREATM                                 |         |  |                     |                |
|          |                                |                     | 1         | ENT RECEIVED, PA IS REQUIRED                                   |         |  |                     |                |
|          |                                |                     |           | FOR ADDITIONAL SERVICE.  |         | 1  |                     |                |
| 3404932  | RANDOLPH/SANDHI                | 0                   | 0         | *** NO DATA TO REPORT ***                                      |         |  |                     |                |
|          | LLS CO MH C                    |                     | +         |  |         | <del> </del>                                     |                     |                |
|          |                                |                     | 1         |  |         | 1  |                     |                |
|          |                                |                     |           |  |         |  |                     |                |
|          |                                | 0                   | 0         |  | 0       | 0  | 0                   | C              |
|          |                                |                     |           |  |         |  |                     |                |
| 3404933  |                                | 21                  | 30        | DUPLICATE OF CLAIM-SYSTEM                                      |         |  |                     |                |
| 3404333  | SOUTHEASTERN CT<br>R FOR MH/DD |                     |           | DOLLAR OF CAMER OF CAMER                                       |         |  |                     |                |
|          | it folt fill/ bb               |                     |           |  |         |  |                     |                |
|          |                                |                     |           |  |         |  |                     |                |
|          |                                | 8599                | 15        | DETAIL NOT COVERED BY COMBINAT                                 | 6       | 80   | 2188                | 2108           |
|          |                                |                     |           | ION OF RECIPIENT, PROVIDER AND                                 |         |  |                     |                |
|          |                                |                     |           | BENEFIT PACKAGE.   |         |  |                     |                |
|          |                                | 11                  | 11        | CLIENT NOT ELIGIBLE ON SERVICE                                 |         |  |                     |                |
|          |                                |                     |           | DATE   |         |  |                     |                |
|          |                                |                     |           |  |         |  |                     |                |
|          |                                |                     |           |  |         |  |                     |                |
| 3404934  | ONSLOW CARTERET                | 8599                | 78        | DETAIL NOT COVERED BY COMBINAT                                 |         |  |                     |                |
|          | BEHAV HEAL                     |                     |           | ION OF RECIPIENT, PROVIDER AND                                 |         |  |                     |                |
|          |                                |                     |           | BENEFIT PACKAGE.   |         |  |                     |                |
|          |                                | 11                  | 73        | CLIENT NOT ELIGIBLE ON SERVICE                                 |         | 0.00   | 075                 |                |
|          |                                |                     |           | DATE   | 1       | 263  | 875                 | 612            |
|          |                                |                     |           |  |         |  |                     |                |
|          |                                |                     |           |  |         |  |                     |                |
|          |                                | 8535                | 68        | SERVICE FACILITY LOCATION WAS                                  |         |  |                     |                |
|          |                                |                     | 1         | NOT INCLUDED IN YOUR 837.                                      |         |  |                     |                |
|          |                                |                     | 1         | PLEASE RESUBMIT YOUR CLAIM WIT                                 |         |  |                     |                |
| 3404935  | MAYNE OO MENERT                | 0                   | 0         | *** NO DATA TO REPORT ***                                      |         | <del> </del>                                     |                     |                |
|          | WAYNE CO MENTAL<br>HEALTH CTR  |                     | +         | 1 1  |         | <b>-</b>   |                     |                |
|          |                                |                     | 1         |  |         | 1  |                     |                |
|          |                                |                     |           |  |         |  |                     |                |
|          |                                | 0                   | 0         |  | 0       | 0  | 0                   |                |
|          |                                |                     |           |  |         |  |                     |                |
| 2404924  |                                | 9500                | 114       | DETAIL NOT COVEDED BY COMPANY                                  |         |  |                     |                |
| 3404936  | WILSON-GREENE M<br>ENTAL HEALT | 8599                | 114       | DETAIL NOT COVERED BY COMBINAT  ION OF RECIPIENT, PROVIDER AND |         | <del>                                     </del> |                     |                |
|          | BRIAD BEADT                    |                     | +         | BENEFIT PACKAGE.   |         | <b>-</b>   |                     |                |
|          |                                |                     | 1         |  |         |  |                     |                |
|          |                                | 8932                | 9         | CMTNC INELIGIBLE TO RECEIVE SE                                 | 10      | 131  | 698                 | 567            |
|          |                                |                     |           | RVICES IN IPRS.  |         |  |                     |                |
|          |                                |                     |           |  |         |  |                     |                |
|          |                                | 21                  | 5         | DUDITORE OF CLAIM-CVCTTM                                       |         |  |                     |                |
|          |                                | 21                  | 3         | DUPLICATE OF CLAIM-SYSTEM                                      |         | -  |                     |                |
|          |                                | 1                   | +         |  |         | <del>                                     </del> |                     |                |
|          |                                |                     | +         |  |         | <del> </del>                                     |                     |                |
| 3404937  | EDGECOMBE NASH                 | 21                  | 63        | DUPLICATE OF CLAIM-SYSTEM                                      |         | 1  |                     |                |
|          | MNTL HLTH C                    |                     |           |  |         |  |                     |                |
|          |                                |                     |           |  |         |  |                     |                |
|          |                                |                     |           |  |         | ļ  |                     |                |
|          |                                |                     |           |  |         |  |                     |                |
|          |                                | 0                   | U         |  | 0       | 63   | 382                 | 319            |

|           |  |              |           |   |         |  | TOTAL     | TOTAL  |
|-----------|--|--------------|-----------|---|---------|--|-----------|--------|
| PROVIDER  | 1  | HIGH DENIAL  | NUMBER OF |   | TNC     | TOTAL  | CLAIMS    | CLAIMS |
| NUMBER    | PROVIDER NAME                                    | EOBS         | DENIALS   | DESCRIPTION   | DENIALS | DENIALS  | FINALIZED | PAID   |
|           |  |              |           | *** NO DATA TO REPORT ***                                     |         |  |           |        |
| 3404938   | VGFW DBA RIVERS                                  | 0            | 0         | *** NO DATA TO REPORT ***                                     |         |  |           |        |
|           | TONE COUNSE                                      |              |           |   |         |  |           |        |
|           |  |              |           |   |         |  |           |        |
|           | +  | 0            | 0         |   | 0       | 0  | 0         | (      |
|           |  |              |           |   |         |  |           |        |
|           |  |              |           |   |         |  |           |        |
| 3404939   | NEUSE MENTAL HE                                  | 8535         | 179       | SERVICE FACILITY LOCATION WAS                                 |         |  |           |        |
|           | ALTH CENTER                                      |              |           | NOT INCLUDED IN YOUR 837.                                     |         |  |           |        |
|           |  |              |           | PLEASE RESUBMIT YOUR CLAIM WIT                                |         |  |           |        |
|           |  | 11           | 28        | CLIENT NOT ELIGIBLE ON SERVICE                                | _       |  |           |        |
|           | +  |              | 20        | DATE  | 0       | 214  | 589       | 375    |
|           | +  |              |           |   |         |  |           |        |
|           | 1  |              |           |   |         |  |           |        |
|           |  | 8599         | 7         | DETAIL NOT COVERED BY COMBINAT                                |         |  |           |        |
|           |  |              |           | ION OF RECIPIENT, PROVIDER AND                                |         |  |           |        |
|           |  |              |           | BENEFIT PACKAGE.  |         |  |           |        |
|           |  |              |           |   |         |  |           |        |
| 3404941   | PITT CO MH/DD/S                                  | 8329         | 9         | CLAIM DENIED ATTENDING PROVIDE                                |         |  |           |        |
|           | AS CENTER  |              |           | R CANNOT BE THE SAME AS<br>THE LMA                            |         |  |           |        |
|           | +  | +            | 1         |   |         | <del>                                     </del> |           |        |
|           | +  | 191          | 7         | CLIENT ID NUMBER DOES NOT MATC                                |         | 17   | 75        |        |
|           | 1  | †            |           | H PATIENT NAME  |         | 17   | /5        | 50     |
|           | 1  | 1            |           |   |         | 1  |           |        |
|           | 1  |              |           |   |         |  |           |        |
|           |  | 23           | 1         | SERVICE REQUIRES PRIOR APPROVA                                |         |  |           |        |
|           |  |              |           | L   |         |  |           |        |
|           | 1  | 1            |           |   |         |  |           |        |
| 2404042   |  | 1.1          | 75        | CLIPPE NOT BUTCHER ON CONTROL                                 |         | ļ  |           |        |
| 3404942   | ROANOKE CHOWANH                                  | 11           | 75        | CLIENT NOT ELIGIBLE ON SERVICE DATE                           |         | 1  |           |        |
|           | UMAN SERVIC                                      |              |           | DATE  |         |  |           |        |
|           | +  |              |           |   |         |  |           |        |
|           | +  | 8599         | 59        | DETAIL NOT COVERED BY COMBINAT                                | 2       | 255  | 1780      | 1525   |
|           | +  |              |           | ION OF RECIPIENT, PROVIDER AND                                | ,       | 233  | 1700      | 132.   |
|           | 1  |              |           | BENEFIT PACKAGE.  |         |  |           |        |
|           |  |              |           |   |         |  |           |        |
|           |  | 79           | 24        | THIS SERVICE IS NOT PAYABLE TO                                |         |  |           |        |
|           |  |              |           | YOUR SUBMITTED BILLING  |         |  |           |        |
|           |  |              |           | PROVIDER TYPE AND SPECIALTY IN                                |         |  |           |        |
| 3404943   | +  | 8599         | 211       | DETAIL NOT COVERED BY COMBINAT                                |         |  |           |        |
| 2404242   | ALBEMARLE MENTA                                  | 0393         | 211       | ION OF RECIPIENT, PROVIDER AND                                |         |  |           |        |
|           | L HEALTH CE                                      |              |           | BENEFIT PACKAGE.  |         |  |           |        |
|           | +  |              |           |   |         |  |           |        |
|           | +  | 8931         | 30        | AMTNC INELIGIBLE TO RECEIVE SE                                | 58      | 295  | 1035      | 740    |
|           | -  |              |           | RVICES IN IPRS.   |         |  |           |        |
|           |  |              |           |   |         |  |           |        |
|           |  |              |           |   |         |  |           |        |
|           |  | 8935         | 28        | ASTNC INELIGIBLE TO RECEIVE SE                                |         |  |           |        |
|           |  |              |           | RVICES IN IPRS.   |         |  |           |        |
|           |  |              |           |   |         |  |           |        |
| 3404944   | EXCEDITATE HAVE                                  | 21           | 103       | DUPLICATE OF CLAIM-SYSTEM                                     |         | <del>                                     </del> |           |        |
| - 10-1319 | EASTPOINTE HUMA<br>N SERVICES                    | -            |           |   |         | <del>                                     </del> |           |        |
|           | N DERVICES                                       | +            | 1         |   |         | <b> </b>   |           |        |
|           | 1  | <del> </del> | 1         |   |         |  |           |        |
|           | 1  | 8599         | 10        | DETAIL NOT COVERED BY COMBINAT                                | 12      | 133  | 1789      | 1650   |
|           |  |              |           | ION OF RECIPIENT, PROVIDER AND                                |         |  |           |        |
|           |  |              |           | BENEFIT PACKAGE.  |         |  |           |        |
|           | 1  | 1            | L         |   |         |  |           |        |
|           |  | 8931         | 8         | AMTNC INELIGIBLE TO RECEIVE SE                                |         |  |           |        |
|           |  | 1            |           | RVICES IN IPRS.   |         | ļ  |           |        |
|           | <del>                                     </del> | 1            | 1         |   |         | 1  |           |        |
| 3404946   |  | 0            | 0         | *** NO DATA TO REPORT ***                                     |         | -  |           |        |
| -101510   | FOOTHILLS AREAM<br>ENTAL HEALT                   | +            | 1         | DIAMA TO MALONA   |         | <del>                                     </del> |           |        |
|           | ENIAL REALT                                      | 1            | 1         |   |         | <del>                                     </del> |           |        |
|           | 1  | <del> </del> | 1         |   |         |  |           |        |
|           | 1  | 0            | 0         |   | 0       | 0  | 84        | 84     |
|           | 1  |              |           |   |         | 1  |           |        |
|           |  |              |           |   |         |  |           |        |
|           |  | 23           | 44        | SERVICE REQUIRES PRIOR APPROVA                                |         |  |           |        |
| 3404957   | TIDELAND MENTAL                                  |              |           | T.  |         | _  |           |        |
| 3404957   | TIDELAND MENTAL<br>HEALTH CTR                    |              |           |   |         |  |           | İ      |
| 3404957   |  |              |           |   |         |  |           |        |
| 3404957   |  | 0500         | 10        | DESTAN NOW COURDED BY COURSE                                  |         |  |           |        |
| 3404957   |  | 8599         | 13        | DETAIL NOT COVERED BY COMBINAT TON OF RECIPIENT, PROVIDER AND | 3       | 66   | 446       | 380    |
| 3404957   |  | 8599         | 13        | ION OF RECIPIENT, PROVIDER AND                                | 3       | 66   | 446       | 380    |
| 3404957   |  | 8599         | 13        |   | 3       | 66   | 446       | 380    |
| 3404957   |  | 8599         | 13        | ION OF RECIPIENT, PROVIDER AND                                | 3       | 66   | 446       | 380    |
| 3404957   |  |              | 13        | ION OF RECIPIENT, PROVIDER AND<br>BENEFIT PACKAGE.            | 3       | 66   | 446       | 380    |
| 3404957   |  |              | 13        | ION OF RECIPIENT, PROVIDER AND<br>BENEFIT PACKAGE.            | 3       | 66   | 446       | 380    |

|          |                 |             |           |                                |         |         | TOTAL     | TOTAL  |
|----------|-----------------|-------------|-----------|--------------------------------|---------|---------|-----------|--------|
| PROVIDER |                 | HIGH DENIAL | NUMBER OF |                                | TNC     | TOTAL   | CLAIMS    | CLAIMS |
| NUMBER   | PROVIDER NAME   | EOBS        | DENIALS   | DESCRIPTION                    | DENIALS | DENIALS | FINALIZED | PAID   |
|          |                 |             |           |                                |         |         |           |        |
| 3404979  | NEW RIVER AREAM | 8599        | 19        | DETAIL NOT COVERED BY COMBINAT |         |         |           |        |
|          | H/DD/SA PRO     |             |           | ION OF RECIPIENT, PROVIDER AND |         |         |           |        |
|          |                 |             |           | BENEFIT PACKAGE.               |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
|          |                 | 120         | 11        | CLIENT ID NUMBER MISSING OR IN | 0       | 40      | 1960      | 1920   |
|          |                 |             |           | VALID. ENTER CID AND SUBMIT    |         |         |           |        |
|          |                 |             |           | AS A NEW CLAIM                 |         |         |           |        |
|          |                 |             |           |                                |         |         |           |        |
|          |                 | 21          | 10        | DUPLICATE OF CLAIM-SYSTEM      |         |         |           |        |